DOCUMENT RESUME

ED 194 517 SP 017 072

AUTHOR Silver, George A.
TITLE Redefining School Health Services: Comprehensive Child Health Care as the Framework.
PUB DATE 15 Oct 80
NOTE 23p.: Paper presented at the Annual Meeting of the American School Health Association (Dallas, TX, October 15, 1980).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Delivery Systems: Dental Health: Elementary Secondary Education: Health Education: Mental Health: Nutrition: Physical Health: Preventive Medicine: *Primary Health Care: *School Health Services: *School Nurses: School Role: *Social Action: *Student Needs

ABSTRACT

Recognizing the needs, deficiencies, and diversity of school health services is prerequisite to any analysis of need. More uniform programs and more equitable access for all school children to whatever minimal standard of health services should be provided: periodic examination, some limited medical care on the school grounds, intensive health education activities in a variety of categories, and more exacting standards for the professional medical people in the school health system--both doctors and nurses. Current school health services can be extended to provide: more inclusive primary care: effective outreach and home visiting on behalf of the children: preschool examination: and assessment and primary care for preschoolers and siblings. (Author/JD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED194517

REDEFINING SCHOOL HEALTH SERVICES: COMPREHENSIVE CHILD HEALTH CARE AS THE FRAMEWORK

Prepared for presentation at the American School Health Association's Annual Meeting, Dallas, Texas, October 15, 1980.

SP017 072

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

George A. Silver

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

REDEFINING SCHOOL HEALTH SERVICES: COMPREHENSIVE CHILD HEALTH CARE AS THE FRAMEWORK

There appears to be a current of dissatisfaction with school health services, in part related to the nature of the services, or lack of them; in part to the confusion of responsibilities between health and education agencies. In the community itself there is no consensus on the degree to which parents, community health and medical care providers, and the school system should assume responsibility for children's health needs. In recent years, a kind of moratorium on the discussions and arguments has taken place in anticipation of the imminent passage of a national health insurance program.

In any case, school children, like children generally in our culture, seem to be caught in a cross-fire of professional, traditional and political struggles - innocent victims, that is, of social attitudes and values which offer children no priority in concern or resources.

On the broader canvas, for example, one can see no social measures specifically directed toward children, no universal family or children's allowances; no legislative entitlement to care or services, aside from the means-tested allowances and services doled out to poor children. Juvenile justice has few of the guarantees adhered to for adults and its administration and effects are under strong and continuing criticism.

Lip service to the family as guardian and representative for the child receives no social support: parents are responsible - state

interference is resented and rejected. The child's interest is presumably best protected by the parents rather than society. While this may be true in the vast majority of cases, in those cases where it is not true, there is virtually no channel available for correction.

Associated with this failure of social support is the ambivalence induced by the still unsettled views of the American people regarding the working mother. Women are needed in the economy, however discriminated against in terms of status, promotion or wage levels. Forty percent of mothers with small children at home or in school are working. Nevertheless, society has not taken the necessary steps to arrange for careful and conscientious care for the children of working mothers: protected, carefully supervised, properly equipped day care centers; feeding programs either in the community or in the schools that would guarantee adequate nutrition for these children who may not have access to proper meals at home, for breakfast and lunch; after school programs that would protect and supervise the children in the interval between the end of the school day and the return of the working mother from her employment.

Child health services in the US are admittedly inadequate in that our infant mortality places at a very low level - 16th in the world - which is scandalous considering our great wealth and material resources. Although this is commonly excused as part of the penalty we pay for not taking care of the poor and minority groups, the fact is that the record for the majority population and upper income groups isn't all that good - in our best situations we barely approximate the average for Sweden or the Netherlands. And other countries have minority problems, the Netherlands,

for example, considered the epitome of homogeneity, has about 10 percent Indonesian and Surinamese who require the kind of special consideration that American Black and Chicano/Latino groups need, but in the Netherlands they get it.

And that is only a small part of the evidence of inadequacy. Deaths of children under 5 years of age are among the highest in industrialized countries. There is a rising suicide rate among young people that puts us at the top of the bracket in that category, and of course in homicides among young people we lead the world. There is accumulating statistical evidence of malnutrition, not only from iron deficiency, but from protein calorie malnutrition, similar to the malnutrition of children in very poor countries. Hunger is a great barrier to learning, the drowsiness and weakness of malnutrition is hardly helpful to a child in following or in understanding classroom work, let alone doing homework.

So far as the school health standards are concerned, despite requirements for immunization against recognized preventable diseases of childhood, a significant percentage of poor and minority children enter school without such protection and are not followed-up to see that it is done. Even the kids who enter as "immunized" are often given this protection just at the time of admission to school, although we know quite well that the dangerous periods of exposure to infection are in younger age groups. Epidemics of otherwise preventable disease, such as diphtheria, polio or typhoid fever, whooping cough are found among minority children. An epidemic of diphtheria in San Antonio not too many years ago showed 12 times as many brown as anglo children suffering the attack of that disease.

Handicaps are not found as readily or completely as they might be among school children because of the lack of integrated and systematic case-finding and follow-up. If the child is eligible for Medicaid and an EPSDT examination is prescribed by state regulation, the statistics show that about 11 percent of the eligible kids have been examined and possibly half of those followed to see if the recommended treatment has been given. Millions of children who have had their eyes examined in school vision programs are without glasses. Thousands of children examined and found to need hearing aids are without them. We all know that kids who can't see the blackboard or hear the teacher are least likely to keep up with the material, more likely to be troublesome in class.

So far as the specific attention to health needs of children is concerned, additional obstructive factors are evident. Unlike most other industrially advanced countries in the world, and a great many less advanced countries, I may add, the US has no universal health or medical care plan for the population. True, most of the population is covered by some kind of private or public health insurance, for more or less of the costs of medical care (mostly less), but this is not the same as a guarantee of access to medical care, or health service as needed. It is no guarantee whatever to those 20 percent concentrated in the ranks of the working poor, who have no insurance. It is no guarantee of the provision of the preventive services for children, who, much more than adults need these services to prevent illness and disability and early death.

School health services are additionally hedged about with restrictions that make the range of response to children's health needs less than adequate. On the professional side, consideration for the entrepreneurial nature of American society compels us to reject medical care in or through the schools: we may look for handicaps, illness, medical care needs; we may recommend correction or treatment. But the actual correction, the actual provision of services, must be left to the parents and taken care of in the private sector. It is not the child's needs which are paramount, it is the primacy of the family role that is to be protected; it is the entrepreneurial nature of medical practice that is to be preserved. The child's needs are a tertiary priority.

Even in those circumstances in which family and professional dominance yield a bit, and the school is given some health responsibilities - more elaborate case-finding, and in some gingerly fashion, responsibility for care - an inter-professional conflict intrudes. Case-finding and follow-up in the interest of the child requires a three-cornered arrangement - nurse or medical professional, teacher and parent. The absence of participation of any one of these makes effective action on behalf of the child much less likely. In the event, teachers, teaching supervisors and administrators tend to take the position that teaching is a full-time occupation - they are impatient with a system that takes them away, as they see it, from their duties. There is hardly enough time for implanting the educational programs, how can they be expected to look for, attend to and repair health needs? And take time, their own or educational time, to

meet with nurses and parents for health problems? If the health professionals can't take care of their own problems, why should this be the teachers' additional task?

There is another side to this, though. This is the professional jealousy that says, anything that takes place in a school is a school program. It may be called health, or concerned with health matters, but it is in the school area and so it should be planned, staffed and administered by school people. This kind of tug-of-war further limits the range and effectiveness of any school health program. On the one hand, the educational hierarchy is impatient with non-educational activities in the educational orbit; on the other, whatever goes in the school must belong to educators. If the educators are successful in dominating the terrain, little health input will be demanded of the teachers; if they are not, little cooperation will ensue. The results in either case will hardly be beneficial to the children.

Teachers are busy - lesson plans, staff meetings, preparation for class, marking papers, student conferences. Nurse-teacher conferences are the exception not the rule. Nurse-parent-teacher conferences are unheard of. In the urban slum schools, parents are difficult to reach, in the homes where nearly 50 percent of the mothers are now working, it is unlikely a parent can be brought to school for any reason. What do we do about a kid who is sick and ought to go home? We have no visiting or out-reach service to the family. If there were arrangements for evening visits to the home, who would go? And if the visits were to be to the school, how many parents would come?

Outreach is needed, not only because of the follow-up on the findings of traditional handicaps, like glasses or hearing aids, but because of what has come to be known as the "new morbidity": smoking in the preteen ages; drug, alcohol and other substance abuse; venereal disease in very young children; teenage pregnancies. These are matters that concern the schools, the parents, the health authorities. And they cannot be solved, or even reached, without joint efforts. All these illnesses, handicaps and untreated conditions affect education and must affect educators and the quality of what they can do.

Mental and emotional problems are even more difficult to handle simply as medical or entirely as classroom teacher's problems. We lack sufficient facilities and resources to provide the complex guidance, support and treatment that emotionally and mentally ill children and their families need. Can the schools intervene favorably in some cases? In which ones? How? There is little in the way of effective models to help teachers, school nurses, principals and school doctors cope with these problems. And "mainstreaming" makes the task harder and larger. Parental neglect and child abuse, often easily recognizable in the child in the classroom is impossible to deal with under current circumstances through the school system. Reporting yes; early case-finding and help, probably not.

In addition to these limitations and obstacles is the conflict in the professional relations between doctor and nurse, a conflict growing increasingly acute, whose dimensions diminish the effectiveness of a

school health program in any case. Nurses are rarely given independent authority or responsibility and this then is reflected in their approach to their duties, sometimes tentative, fearful and less than fully responsible. In other cases, since training for effective independent action will be lacking for these same reasons, the nurse may be insufficiently qualified for the responsibilities and requirements of the job so that if she does take purposeful action, it may be worse than inaction.

Altogether, the lack of social support structures, institutional and financial; social commitment to the family rather than the child; entrepreneurial philosophy; inter- and intra-professional competition and struggles all serve to isolate the child from any useful and effective school health service.

In any case, professional groups: educators, physicians and administrators have failed to address themselves to the major issue, which is the health of the children. We have conferred upon structure, governance, manpower development and content, especially the limitations imposed by professional considerations. But we have not addressed ourselves to the matter of what the children need overall, how this is being managed, what part school health services can play in providing a piece of, or all of, the health care needs of the child. We have not discussed integration of the fragments we create in dividing the child into home and school pieces, into prevention and curative pieces, into mental and physical pieces, into nurse, teacher and doctor pieces. Nor have we examined the evils inherent in an economically oriented medical care

system, in which the poor and minority group children are forced to suffer more illness and fewer opportunities for care - the "inverse care law" - and in which the school is not recognized and used as the potential corrective to these inequities it could be.

Whatever the commitment of the parents, as exemplified in the statements and actions of the national PTA organizations, none of the sacred cows have been sacrificed: health education goals have been vigorously pursued, since this does not challenge the primacy of the family, except that where it does, as in sex and family life education programs, the PTA has been so polarized that often programs are not undertaken, abandoned or provided in such tentative fashion as to be ineffective. In any case, health education is rarely associated with social reality. Dental health education has not been generally associated with dental health programs - case-finding and treatment of dental ills. Nutrition education has not been associated with effective nutrition programs. Attention to health, as promoted in the health education agenda, has not been associated with effective case-finding and treatment of handicapping and health limiting conditions among the children.

Again, it is clear, that the children are not the priority but social shibboleths take precedence.

This is not to say that no one cares, that there have not been efforts, or that efforts do not continue, to change all this and provide bold and far-reaching programs for children that would effectively look after their health and well-being. In the 30s, the NYC Health Department

pioneered the Astoria Plan; its limitations are the limitations imposed by the critical comments noted earlier. States legislate the physical examination of all school children with questionable results. School doctors do examine children when requested, parents do file reports of the examination performed by the family physician. But without information from parents and teachers, without out-reach and follow-up, the examination itself is no more than a formal gesture. The report filed by the family doctor may or may not reflect careful and considered information of use to the school and the child, if used at all. And since the parents had initiated the action, and presumably were familiar with the facts, what follow-up could the school undertake?

Agencies, groups and individuals concerned about child health are still stubbornly active in promoting change and improvement. The activity now seems to be directed much more toward coordination, to take advantage of existing programs and policies so as not to stir up opposition by advancing controversial new approaches, which might challenge the medical profession, or dental profession or the educational establishment. A report from some states - New York State, Pennsylvania among others - appears to establish this trend. The Robert Wood Johnson Foundation has undertaken major financing in four states, following an experimental demonstration in a school in Hartford, CT. There is hope.

State and local laws provide that school health services must be provided. But these services are uneven in quality and quantity and

often exist only insofar as they fulfill the letter of the law. There is uneven compliance with the law or regulations on the standards of personnel and availability. The resistance to cooperation, largely because of vigorously narrow role interpretation, is widespread. Taxpayers grumble about increases in school rates, blame duplication of services and unnecessary frills in school expenditures. Whatever school funds can be made available, they say, should go for good teachers and good teaching.

Funding sources raise another difficult point. Very little money is appropriated specifically for school health. There is lots of competition for ESEA Title I money.

Congress ordered the Department of Education to set up an office to promote health education in the schools. An Office of Comprehensive School Health exists in the Department. They prepared a broad program of education - not services, you understand - including campaigns against smoking, cancer, venereal disease, pregnancy in unmarried school children, that is, and so forth, but Congress has yet to appropriate money.

School nurses, despite statements and announcements in the professional journals, despite outlines of proposed areas of concern and action, despite the requirement for qualification in the field, despite the training programs and degrees offered, school nursing is not a uniform professional calling. Retired hospital nurses, local nurses without specialized experience or orientation whose hours of work are congruent with their children's schooling are hired for the job. There is no uniform standard

of admission to the role, no salary floor or level. Three states recognize a specific special category of school nurse; a few others allow but do not require a nurse-practitioner to do the job. Many states require a certification for the job, but do not specify the qualification.

Henry Silver and the Colorado group have prepared a special curriculum to train the School Nurse Practitioner and give added training in school health to the Pediatric Nurse Practitioner. Those standards apply to the few nurses employed in Colorado. And in Maine, I think.

School health authorities don't want to, and school administrators don't see the need to, tangle with dentists either. Seventy percent of poor children don't see a dentist even once a year. Very few schools have full-scale dental programs; very few states add dental services to the Medicaid provided services. The dental nurse, so successful in New Zealand for generations, and now extensively used in Saskatchewan, is unknown in the USA.

Those who have studied the dental situation internationally, especially the problem of reaching children, have come to the conclusion that school dental programs are feasible, and with the effective use of auxiliaries, relatively inexpensive. I know I need not elaborate on the New Zealand experience or define the dental nurse for this audience. Suffice it to say that these nurses, with two years experience in a training program that gives them capability in simple diagnostic and oral hygiene procedures, simple restorative dentistry and extraction procedures for deciduous teeth, carry the burden of dental care for children, particularly in the schools.

In the United States, on the other hand, it is only against great odds that 21 states have passed laws permitting expanded functions to be carried out by auxiliaries. One dental observer writes:

> Unless massive progress is made in prevention, there seems to be little hope that the delivery of dental care will ever keep pace with the occurrence of dental disease in this country.
>
> At present, hardly more than one-third of the need for primary dental care, as perceived by dentists in the United States, is being met.

It is true that for many years there has been a working arrangement between the ASHA and the ANA regarding school nurses, defining the role and responsibilities and suggesting the background and training requirements. However, there is nothing these organizations can do to enforce the proposed requirements. And, given the attitudes and social climate in which school health services are designed and provided, little would be expected to be done, and little has been done, to make these recommendations a reality. It takes money, in the first place, lots of money, to train, educate and recompense the kinds of school nurses the agreement envisions. It takes orientation - which takes time - and administrative conviction for teachers to take the plans and the nurses seriously. It takes a program and a career line for nurses to take the role seriously.

School nurses represent a respectable community among nurses - nearly 100,000 or about 10 percent of the working population of nurses. Their income is hard to judge because so many of them are part-time. To a considerable extent, also, they are exploited because they seek the

kind of employment the role today represents, with the lesser demands in time, activity and responsibility it has come to mean.

For school nursing to become the responsible social career parallel to the socially necessary role of health promotion, preventive service and health care for children, a number of conditions must be met. And even after these conditions are met, there is the additional question of whether an independent school health service is practical, or desirable.

From the standpoint of the kind of needs there are, and recognizing the deficiencies in the nature and structure, as well as lack of uniformity, in the existing school health services, several alternatives present themselves. We can make special efforts to improve the present situation: more uniform programs and more equitable access for all school children to whatever minimal standard of health services is to be provided: periodic examination, some limited medical care on the school grounds, intensive health educational activities in a variety of categories, more exacting standards for the professional medical people in the school health system - both doctors and nurses. And we can move to extend the service to be provided - more included in the definition of primary care; effective out-reach and home visiting on behalf of the children; pre-school examination, assessment and primary care for preschoolers and siblings.

That's one way to go, and from American political history it may be the only way to go. It's what is commonly called "incrementalism" and implies that however radical the goal, the preliminary steps are always

small and conventional. But there is another way, not incremental, that sometimes succeeds, particularly when people are tired of inaction and ineffective action, of promises and blighted expectations over a long period of time. It is particularly possible when there is a powerful advocacy group that supports more extensive and more radical change. Medicare for example, was the fruit of long and bitter debate and the failures of several less ambitious attempts, along with the pressure of a united senior citizens group.

It would not be easy to create a wholly new and totally unrelated system even if there were an effective advocacy group for children, which there isn't; and even if there were widespread agreement on the nature of the changes that ought to be made, which there isn't.

However, there is growing interest in renovation of the American medical care system, originally stemming from the excessive costs and implacable inflation of the medical care system but now joined with influences that aim at changes in organization and staffing: HMOs, use of physician assistants and nurse practitioners, midwives, for example, rather than the original almost total emphasis on tinkering with financial and insurance arrangements.

For some years I was engaged in a study of the federal/state interface in the field of child health, and examined the forces at work that obstructed improved and necessary care for children. It was clear that the major obstacle in the US was the lack of a structured form for the delivery of services to children. I then undertook to examine a series

of child health programs in Europe, where there are uniformly national health programs that include children. To my surprise, I discovered that a national health program by itself was no guarantee that children would receive the maximum benefit available: early diagnosis and treatment; school health supervision and follow-up; immunizations and corrections of handicapping conditions. In order for children to receive the benefits to which they were entitled, and to assure the health and well-being of the next generation, there had to be a specific child health program.

Furthermore, the best of the programs that were focussed on children, like Finland and the Netherlands, were nurse directed and nurse controlled. Even in Sweden, where the nurse was not so clearly in charge, but subject to the local county health officer for program design and supervision, the nurse actually carried the full preventive role. It is amusing to read in the report of a special survey and controlled study of the results of the examination of 4-year olds, that the findings of the Swedish public health nurse were more accurate than those of the family doctors, and the equivalent of the results of the pediatric residents.

It would appear too, that a health care system for children cannot be only an examination, or immunization, or treatment system. There has to be an educational component, because much of what determines the health of adults derives from the behavior patterns that are instilled in childhood. Tobacco, drug and alcohol abuse represent failures of education as well as social problems; so do teenage pregnancies in

unmarried women; so do venereal diseases. The relation of the nurse to the family, the reliance of the family, including the children, upon the nurse's skills and her philosophy of health, is a basic element of any preventive service.

Where there is a disordered relationship in the home, in the relation between parents and children, that may be expressed as school absenteeism, a behavior problem, child abuse and/or neglect, a continuing relationship with the school nurse will have uncovered the problem before it becomes manifest. This is a powerful preventive element. Where it does occur, the same continuing relationship of school nurse with the family can be therapeutic as well.

In those years, when we were reviewing child health policy in the United States, we puzzled over the singular ineffectiveness of most public programs and were about to conclude that the real problem was with the American people, that they didn't care enough about children to make any program work properly. However, from the study of European child health systems, the reasons become obvious. So long as there is no structure within which services can be carried out in a formal, systematic way, a significant number of children, and usually the children from the most deprived and neediest part of the population, will fail to obtain services. The European experience demonstrated too, that universal health system coverage was not enough, because family doctors and nurses would be so overwhelmed with sick people that they would not have either the time or inclination to take care of preventive

services in children: well-baby care, preschool examination and assessments, school health examinations and follow-up, counselling and guidance, home visits and the like. In order for these preventive services to be carried out effectively, a separate health system, a preventive service has to be established, and it ought to be controlled and supervised by the kind of professional people chiefly interested in preventive services, not medical care. That is why the most effective services in any European country are those in the control of nurses rather than physicians.

School health services cannot be considered in a vacuum. They must become an integral part of the total care of the child. If we had a national health care system, we might battle for liaison and integration in order to accomplish this. Not having a national system, and the likelihood of getting one seems increasingly remote, it is my judgment that we need to organize and struggle for a comprehensive health program for children, a part of which will be the school health services. The major emphasis in such a program needs to be preventive and case-finding, of course. If major funding sources now available from the federal government and the matched funds from state and local sources were put together into a comprehensive preventive program for children, of which the school health service would be a part, hardly any additional monies would have to be found.

Medical care for children is inexpensive, compared with the cost of medical care for adults and old folks, because children require so little

in the way of hospitalization. A modest increment in private insurance, the addition of modest federal appropriations for medical care would cover the cost of services over and above the preventive and primary care services envisioned here. The bulk of what is being spent now, pooled into a coordinated preventive program, would suffice. In Holland, the health officer of Amsterdam calls his preventive service for children, which includes school health services, "an apple a day", because the cost per day is precisely what an apple costs.

When certain conditions are met, the United States can provide an integrated and coordinated program of school health within a comprehensive system of preventive services. These conditions are, in brief, decentralized direction and funding, cooperative public and private responsibility, administration by pediatric nurse practitioners (and dental nurse practitioners in the case of dental services) with physicians and dentists playing ancillary and consultant roles, associated with, but not controlling, a comprehensive medical care system for children.

The social pressures against massive innovation cannot be ignored. It is relatively easy for me to stand here and tell you what a great program can or ought to be. It is quite another to legislate it. Perhaps it is folk wisdom that dictates that there ought to be a trial on a somewhat smaller scale than that of 220 million people before any radically new program is put into being. It may be that we have had no national health insurance program despite the discussion over the

past 50 or more years, because we have had no pilot program. For most other great change in national custom, there has usually been a state program that showed the way. We have never had a comprehensive universal state health insurance act by which to determine the difficulties and rough spots in order to legislate appropriately nationally. I think we should. But in any case, certainly we ought to do some experimenting with a school health program along these lines.

And when such a state experiment is undertaken, we may be able to learn a great deal more of what we need to know to make a child care program effective. It won't be easy. The difficulties in implementation relate to social philosophy - the same difficulty that has interfered with implementation of a national health insurance program; professional objections - again similar to the problem in implementation of national health insurance; and more directly, the absence of a powerful national advocacy group for children.

You're in a position to make this kind of changed system possible and become the national advocates of a comprehensive program of child health. For the country as a whole, your organization is the spokesman for school health; from a professional standpoint, you have the least to lose. You are already established as the intermediaries for child health services within the school years; it is but a step to assuming responsibility for the childhood years altogether. The establishment of such comprehensive services will also offer strong support to the existing

educational activities you have undertaken. The parental participation envisioned in the preventive program will give you added strength for your health educational activities; the existence of qualified school nurses with specifically designated responsibilities for examination and care will give you channels for communication and reinforcement of your health educational message.

In a recent issue of the Journal of School Health, Bess Buser writes, "There will be no return to the 'good old days' as pictured in the comfortable freedom of choice concerning implementation of regulations at the local level." Nor will there be a return to the good old days of casual health examinations and referral slips. PL 94-142 is stirring up the communities; minority resentment is making health concerns more visible in ghetto communities and creating added demands for service; everywhere there is increasing recognition of the link between health and learning.

Most of us usually say, along with the old Prince, in that magnificent novel, "The Leopard", "Don't you like things as they are?" And few of us have the understanding to respond as the Prince's nephew does, "If we want things to remain as they are, things will have to change."